

## SUMMARY: IDEA EXCHANGES

### *3<sup>rd</sup> Annual Disparities Partnership Forum: Overcoming Disparities – Building Successful Obesity and Diabetes Programs*

On November 18 and 19, 2009, the ADA brought together a diverse group of community leaders and health care professionals from around the country for a two-day meeting in Arlington, Virginia. The meeting focused on the major challenges faced by at-risk minority and underserved populations regarding the prevention, detection, and management of obesity and type 2 diabetes. To promote dialogue among attendees and encourage practical application of concepts and programs, small-group idea exchanges took place during three concurrent sessions. Attendees engaged in lively discussions in which they were invited to think together about how they could put into practice some of the ideas they had heard in the presentations preceding the idea exchange. They were asked to characterize:

- The key points of the preceding presentations.
- The challenges they might face in implementing some of the ideas they heard.
- Ways they might overcome these challenges.

At the conclusion of each idea exchange, attendees identified actions they could implement in their work and community settings.

#### **Idea Exchange 1**

##### **Key Points**

- Prevention of chronic disease will be stressed in upcoming health care reform efforts. There will also be an emphasis on behavior change.
- Even if health care reform passes, disparities will remain.
- Adults and children need to be engaged at the local level, in communities.
- Collaboration is key and partnerships need to be promoted across all levels: federal, state, private, and grassroots organizations.

##### **Challenges**

- Resources are scarce and fragmented.
- Communities have many competing priorities.
- Access to health care can be a challenge for many, and there may be insufficient numbers of providers to accommodate health care reform provisions.
- People will need to be educated about how to use the health care system.
- Health messages are not always consistent.
- Cultural appropriateness and health literacy must be considered in all types of communications, e.g., in the media and between provider and patient.
- Programs must be sustainable.

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##### **Diabetes Information**

call 1-800-DIABETES (1-800-342-2383)  
online [www.diabetes.org](http://www.diabetes.org)  
The Association gratefully accepts gifts through your will.

##### **The Mission** of the American

Diabetes Association is to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

### **Overcoming Challenges**

- Assess a community's assets and resources and use them wisely.
- Teach collaboration and leverage partnerships, particularly with trusted community leaders.
- Work within community organizations and institutions, e.g., churches, colleges, nursing schools.
- Work with local businesses to ensure that communities have affordable, healthy food available.
- Work with local officials to tackle the environmental factors that affect obesity, e.g., safe streets, abundance of fast-food restaurants in poor neighborhoods.
- Identify stakeholders in communities. Listen to what they need, give it to them, and train them.
- Educate community providers about prevention.
- Arm yourself with as much information as possible.
- Develop focused, consistent, high-impact messages based on community needs. Keep the message simple, e.g., "eat less, move more."
- Focus on families.
- Make sure questions on risk for diabetes are included in health assessments, and screen based on risk factors.
- Connect screening to treatment.
- Focus on overall health and chronic diseases, rather than the "disease silo" approach.
- Use provider "extenders," including peer role models.
- Put nutrition labels on vending machines.
- Establish a clearinghouse for promising practices and a method for disseminating existing resources.
- Work with local media and use social media.
- Provide incentives for minorities to enter the health care field.

### **Idea Exchange 2**

#### **Key Points**

- Promote physical activity and healthy food choices in schools.
- Build partnerships and use existing infrastructures.
- Follow up must after screening and link individuals to the services they need.

#### **Challenges**

- Physical education is no longer a priority in most schools.
- Food choices are often unhealthy, particularly in vending machines.
- Individuals/communities do not realize the serious impact of diabetes.
- There is a need to address the mental health issues associated with diabetes, e.g., depression.

### **Overcoming Challenges**

- Develop school-based diabetes curricula for all ages.
- Establish clubs or after-school programs that promote physical activity, e.g., running club, dance club.
- Provide innovative programs, e.g., community gardens, cooking classes, farmers' markets (especially in urban areas).
- Give high school students community service hours to participate in innovative programs that promote health.
- Promote programs for different abilities, e.g., water aerobics for overweight students.

- Partner with organizations such as the YMCA, Boys and Girls Clubs, Parent-Teacher Associations.
- Partner with nontraditional groups such as firefighters, justice, law enforcement.
- Promote Medicare screening in churches. Since many churches are overwhelmed with requests for programs, consider partnering with historically black colleges and universities, fraternities and sororities, and health profession students.
- “Marry” the Medicare screening program with a navigator program.
- Provide local “mini-grants.”
- Encourage the establishment of a national fitness campaign, as was done in the past.
- Identify what you can do – a “baby steps” approach rather than “all or nothing.”
- Use the “promotora” model.
- Suggestions for ADA:
  - Set the standard for what needs to happen after screening.
  - Be the “glue” that keeps local coalitions together.
  - Identify and help local leaders.
  - “Approve” models/programs and disseminate them to communities.

### **Idea Exchange 3**

#### **Key Points**

- One-on-one communication leads to behavior change.
- Programs should be driven by community ownership.
- Programs must be replicable and sustainable.
- Collaboration and partnerships are key.
- The emotional/psychological aspects of diabetes must be addressed.

#### **Challenges**

- There is a gap between research and application of that research.
- The cost to provide screening is an issue.
- Some people see diabetes as inevitable if other family members have it.

#### **Overcoming Challenges**

- Begin education early.
- Stress the urgency of taking action to delay or prevent complications of diabetes, particularly for children diagnosed with type 2 diabetes.
- Use extension services (all states have them) for educational outreach.
- Get medical students involved as volunteers at screenings and give them a cost break on their student loans.
- Build relationships with trusted individuals before program implementation.
- Obtain buy-in from champions, reward them with a sense of progress and acknowledgment of success, and develop new champions.
- Focus on people who are already working in their communities.
- Include mental health professionals in diabetes/obesity prevention meetings.
- Partner with organizations that address co-morbidities, e.g., National Kidney Foundation, Association of Black Cardiologists.

- Partner with the food industry to market healthy foods.
- Make sure to include programs for caregivers.
- Develop tools to assist consumers in asking the right questions of doctors and pharmacists.
- Create consistent messages and tailor them to diverse communities. Messages should be simple, e.g., “Do you know what A1C is? Do you know what yours is? Do you know what to do?”

### **Attendees’ Proposed Actions**

Listed below are the actions attendees said they would take in their communities and work settings over the next 6 months to 1 year. The ADA will follow up on these actions in the following way:

- At the beginning of 2010, the ADA will send the list of actions to all attendees.
- In spring of 2010, the ADA will send a survey to attendees to see what actions they have implemented.
- Toward the end of summer 2010, the ADA will let attendees know what their colleagues have done.

Multiple attendees indicated that they would focus their efforts in the following general areas:

- Developing and delivering consistent messages.
- Fostering and expanding partnerships, especially with nontraditional partners.
- Promoting medical homes.
- Exploring early intervention with children in schools, especially concerning nutrition and what they are eating.
- Bringing the promising practices programs presented at the forum to their communities.
- Educating health care professionals.
- Educating consumers on how to make lifestyle changes.
- Teaching consumers how to navigate the health care system.

Other attendees offered more specific actions they would take, as listed below.

### **Advocacy/Policy**

- Conduct a policy analysis.
- Talk to my “hill” friends about which members set school lunch program policies.
- Become part of a grassroots movement to change the social norms surrounding diabetes.
- Examine more closely the health care reform practices being promoted at a national level in order to provide educated feedback and prepare for what might be reality in the future.
- Mandate that school programs include diabetes education.
- Encourage the Centers for Medicare and Medicaid Services (CMS) and other payers to increase reimbursement of diabetes self-management education.
- Work with community partners to identify policy change priorities.
- Develop a consensus statement.
- Foster local collaboration by encouraging federal agencies to identify their partnerships.
- Create a public policy statement on diabetes that legislators can use in their jurisdictions.

### **Educational Tools**

- Develop a health care consumer agenda: questions consumers can ask for optimal prevention and health management.
- Develop a network-sharing website to share promising practices, ideas, and lessons learned.
- Increase the knowledge base of the underserved so that they are not intimidated by health care providers.
- Create a physician toolkit that assists providers in working with children and their parents in developing a healthy lifestyle.
- Develop web-based tools to engage communities, create a dialogue, and recognize positive changes and best practices ( an “eHarmony” for community-based organizations).
- Contact Joslin Diabetes Center to ask about their tools and what I could replicate.
- Develop a comprehensive chronic disease management education module for patients.
- Enhance the capability to develop educational materials at appropriate reading levels.
- Develop health literacy tools.
- Use materials already available for free or low cost from the ADA, National Diabetes Education Program (NDEP), and Medicare Diabetes Screening Project.
- Develop an electronic database that shows the activities of partner organizations to minimize the redundancy of projects and encourage collaborations.
- Develop a clearinghouse for programs and resources.

### **Improvement of Care**

- Implement continuous quality improvement initiatives.
- Ask the hard questions about our performance and whether we are making a difference.
- Develop a more rigorous connection between programs and the care process.
- Standardize the approach to follow-up.
- Explore how to interest new primary care providers to (1) work for understaffed community health centers and (2) foster primary and secondary prevention.
- Explore the possibility of a patient-centered medical home.
- Promote a multidisciplinary team approach to treating patients with diabetes for better coordination of care.
- Investigate a team-based approach to managing high-risk patients with comorbidities.
- Identify opportunities for enhancing consumer encounters (“point of sale optimization”).
- Make sure that a culturally, ethnically, and racially diverse team is created when reaching out to diverse communities.
- Increase training at the ADA national call center to include health care reform and the resources that may be needed.
- Do a better job at documenting care coordination in relation to diabetes self-management so that better interventions can be designed.
- Explore patient safety initiatives.

### **Partnership Development and Collaboration**

- Identify community leaders and assess resources.
- Explore partnerships with organizations that focus on other conditions that are comorbidities for diabetes (e.g., sleep apnea).
- Explore public/private partnerships to provide diabetes information to families through YMCAs and YWCAs.

- Partner with the YMCA and Boys and Girls Club to promote after-school physical activity.
- Schedule a time to talk to my son's and daughter's classes about diabetes.
- Tap underused volunteer resources such as health profession students and historically black colleges and universities.
- Ask clients to fund research on behavior modification in children with diabetes.
- Encourage our dietetic association to volunteer in schools.
- Reach out to other programs, groups, and agencies to take steps to deliver common and consistent messages.
- Work more with minority consumer and medical groups to promote the benefits of diabetes screening and self-management.
- Engage community-based organizations.
- Enhance partnership performance and outcomes.
- Work with pharmacists in underserved communities to share their space and time to deliver the ADA message.
- Build partnerships with the medical community.
- Work with local health care professionals to build a partnership with the ADA with the goals of (1) educating the community about the seriousness of the disease and (2) screening and identifying those who are pre-diabetic and/or who already have diabetes.
- Build an alliance with ADA for obesity programs in schools.
- Build effective partnerships that link grassroots organizations and health care providers and encourage them to develop community action plans that translate scientific evidence into community action.
- Define a local partnership focused on diabetes-related disparities in communities.
- Ask local ADA leaders to identify partners to spread the message about a healthy environment, beginning with children and schools.
- Expand my work with the Health Resources and Services Administration (HRSA).
- Contact the extension service in my area about possible collaboration to reach the underserved.
- Link apnea support groups with diabetes support groups to promote greater awareness of both conditions.
- Seek more local and state partners.
- Contact agencies and organizations that serve older adults to let them know the resources available for seniors who have diabetes or pre-diabetes.
- Work with the local school district to improve the school lunch program.
- Develop a supportive message that embodies all of the partners.
- Reconnect with other local agencies and resources who are working with people who have diabetes.

### **Program Development/Implementation**

- Find out what does not work.
- Promote programs that are already working.
- Adapt current programs for use by the community rather than developing more programs.
- Identify groups that are already organized and have a demonstrated capacity to bring a promising practice to the community.
- Look into implementing the *Healthy Schools Partnership Program* in neighboring schools.
- Explore the possibility of using information from the *Medicare Diabetes Screening Project*.
- Make recognized programs (e.g., ADA diabetes self-management programs) aware of the *Medicare Diabetes Screening Project* and the tools that are available.
- Request a grant application from the *Medicare Diabetes Screening Project*.

- Disseminate information on the *Medicare Diabetes Screening Project*.
- Pursue bringing *On the Road - Diabetes and Lifestyle Program* to my community.
- Explore *Walking Works* programs that promote walking at work.
- Contact the *Kidney Early Evaluation Program (KEEP)*.
- Implement *Body Works* program.
- Share *Active for Life* program as well as other exercise programs.
- Research an ADA toolkit for schools.
- Develop a school-based activity challenge in partnership with selected Blue Cross Blue Shield plans. Evaluate support from parent-teacher associations (PTAs) and school nurse associations.
- Bring lifestyle and nutrition programs to the attention of different school districts; let them know which ones do and do not work.
- Explore school-based programs.
- Join efforts to do more interventions in schools.
- Go to the neighborhood elementary school to see what the physical education program and food services look like.
- Determine what I can do to help the children in my neighborhood.
- Contact a local junior high school about creating a community garden near the school.
- Begin screening junior and senior high school students for sleep-disordered breathing as a way to determine which children are at greater risk for diabetes, cardiovascular disease, and diabetes.
- Implement a program that increases health education, community involvement, and student empowerment.
- Speak at family reunions.
- Research funding opportunities that will enable the continuation of current, established programs for African Americans, particularly those at risk or already diagnosed with diabetes, as well as youth initiatives.
- Find better ways to connect with community members to (1) get them involved in current programs or (2) develop programs they want, especially in rural areas.
- Bring community leaders together to hear what they think federal partners should do to eliminate disparities in diabetes.
- Develop and implement a certificate training program in diabetes prevention, management, and treatment for community health workers.
- Educate and train people in the community.
- Share information on screening and messaging with support group peer leaders.
- Advocate that pharmacy-based organizations in my community bring in diabetes educators and registered dietitians.
- Do a better job assessing target audiences for outreach.
- Install a community vegetable garden.
- Work with community health centers to form an urban garden project with a nutrition education component and possible involvement of local restaurants.
- Integrate diabetes into community youth leadership development programs.
- Pilot test a peer-support intervention for diabetes management among economically disadvantaged communities.
- Send the ADA call center information on the programs offered through the West Virginia Extension Service.
- Explore evidence-based prevention education programs related to type 2 diabetes in youth.

**Other**

- Communicate the seriousness of diabetes and try to encourage more outrage that diabetes is being ignored, especially in communities disproportionately affected by the disease.
- Implement:
  - Do you know what the test is?
  - Have you had it?
  - What were the results?
  - What do the results mean?
  - What do you need to do with the results?
- Give greater voice to the persons with diabetes that I encounter.
- Empower patients to ask questions.
- Encourage organizers of the forum to provide a means for continued communication among attendees.
- Explore knowledge gateways.
- Work with my clients to identify who could provide funds for research to study behavior modification in children diagnosed with type 2 diabetes.
- Identify the evidence and disseminate it widely.
- Investigate and promote promising community engagement practices.
- Ask my local newspaper to do a feature or series of articles on diabetes identification and management.